

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814



March 2, 1990

Letter No.: 90-23

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

REFERENCE: All County Welfare Directors Letter 89-69

The purpose of this letter is to provide you with additional information and advise you of changes and corrections to existing procedures related to Medi-Cal's Health Insurance Premium Payment (HIPP) Program.

Health Insurance Premium Payment (HIPP) Program - Mandatory Participation

Counties have asked if participation in the Health Insurance Premium Payment (HIPP) Program is mandatory. A recent Department of Health Services (DHS) legal opinion states that DHS may require that Medi-Cal beneficiaries with existing third party health coverage participate in HIPP. This opinion was based on congressional and legislative intent. Therefore, in the event that a Medi-Cal beneficiary refuses to cooperate in Departmental purchase of health insurance, when it is found to be cost effective, the Department may decline payment for medical services which would otherwise be covered by the insurance policy. This information must be communicated by the Eligibility Worker (EW) to potential HIPP participants during HIPP county intake.

HIPP Referral Form

Counties have indicated that there is some confusion regarding the term "Premium Payment Referral Form" which was referred to in ACWDL 89-69. The term was used in reference to the Health Insurance Questionnaire (DHS 6155) (revised May 1989). The Health Insurance Questionnaire (DHS 6155) is the form which is to be used by the counties to make premium payment referrals to the HIPP program. As requested by the counties, the Health Insurance Questionnaire (DHS 6155) is a multi-purpose form. It serves to elicit more detailed information regarding HIPP, Focused Cost Avoidance (based on scope of benefits) and pre-natal and pediatric exceptions to cost avoidance. To avoid confusion in future communications regarding HIPP, we will reference only the Health Insurance Questionnaire (DHS 6155) and discontinue use of the term "premium payment referral form".

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Revisions to Manual Section 15H

Medi-Cal Eligibility Manual procedures entitled "15H -- Health Insurance Premium Payment Program", which were attached to ACWDL 89-69 have been changed as stated below and the changes are reflected in the revised enclosed procedures.

1. Item 2 (b) states that "If the beneficiary cannot be given the Health Insurance Questionnaire (DHS 6155) in person, and the beneficiary notifies the County Welfare Department (CWD) that his/her health insurance has or is about to terminate; or the beneficiary has not applied for the health insurance, the EW must complete this portion of the form". The form should then be sent to the beneficiary for signature with a State addressed return envelope.

Difficulties have been identified with this procedure:

- A) The "State addressed" return envelopes are not available to counties as routine stock and therefore can not be ordered. As a result we are deleting the requirement for the envelopes.
- B) Since the beneficiary's signature is mandatory on the form, it is more efficient to send the form directly to the beneficiary for completion and signature. This will allow the beneficiary to complete the form with information immediately available to him or her. Procedures have been revised to require the EW to send the Health Insurance Questionnaire (DHS 6155) directly to the beneficiary for completion and signature when a HIPP referral is made by phone contact, and the beneficiary cannot be given the form in person. Instructions must also be given to the beneficiary to mail the completed form to:

Department of Health Services
Recovery Branch
Health Insurance Unit (HIPP)
P.O. Box 1287
Sacramento, CA 95812-1287

2. Definition of Health Insurance Coverage, contains an error in the second sentence. The error states "In order to determine a beneficiary's coverage type, six questions have been developed and printed on the Health Insurance Questionnaire (DHS 6155) form (Item No. 5) which should make it easy for a beneficiary to identify his/her type of health insurance coverage". The reference to Item No. 5 is the error. The correct reference is Item No. 10.

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HIPP Participation Criteria

County staff has demonstrated, during county Third Party Liability (TPL) training, enthusiasm and interest in the HIPP program. To help address county staff questions and concerns, the enclosed one page HIPP referral fact sheet was developed. The fact sheet may be provided to Medi-Cal eligibles interested in HIPP participation. Other programs such as the Department of Aging, Developmental Services and the Office of AIDS are successfully using this fact sheet to screen their referrals. The HIPP qualifying criteria are also now a part of Section 15H of the Medi-Cal Eligibility Manual.

If you have any questions regarding this letter or the HIPP program, please contact Pam Langbehn at (916) 739-3260.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: March 2, 1991

15H - - Health Insurance Premium Payment Program

This section provides background information and procedures pertaining to the Health Insurance Premium Payment (HIPP) Program.

1. Program Background

The HIPP Program (Welfare and Institution Code, Section 14124.91) was established by enactment of Assembly Bill 3328 (Margolin, Chapter 940, Statutes of 1986). This law authorizes the Department of Health Services (DHS), whenever it is cost-effective, to pay health coverage premiums on behalf of Medi-Cal beneficiaries. The primary objective of the program is to continue a Medi-Cal beneficiary's other health coverage by paying medical coverage premiums which the beneficiary cannot afford or if he/she decides to cancel existing coverage. Paying premiums for high cost medical users will result in reducing Medi-Cal costs.

2. HIPP Qualifying Criteria

Effective August 1, 1989, Medi-Cal may pay private health insurance premiums for certain qualified Medi-Cal participants. When it is cost effective to do so, Medi-Cal will now pay the insurance premiums for Medi-Cal beneficiaries who have a diagnosis of AIDS, psychosis or other high cost medical conditions (i.e., cancer, heart disease, organ transplants). Persons with a diagnosis of AIDS (and covered under Medi-Cal) will automatically qualify for HIPP. Persons with psychiatric illness and other high cost medical conditions will have to prove that their monthly Medi-Cal covered medical expenses which are paid by the private health insurance carrier are at least twice as much as the monthly premium. Section 7 below, High Cost Medical Conditions, provides a non-exclusive list of medical conditions considered high cost for purposes of HIPP referral.

A Person Qualifies for HIPP if:

- a. There is current Medi-Cal eligibility.
- b. There is a Medi-Cal share of cost of \$150 or less.
- c. There is a high cost medical condition for which the average Medi-Cal covered monthly cost is twice the amount of the monthly health insurance premium.
- d. There is current group or employer related health insurance coverage, or COBRA Continuation, or a conversion policy in effect or available.

- e. Application is made in a timely manner (allowing enough time to process the application and get the premium paid). Timely Application is:
 - 1. If coverage is under COBRA Continuation and application is made within 30 days of the insurance termination date.
 - 2. If coverage is under a conversion policy and application is made within 20 days.
- f. The policy does not exclude the high cost medical condition. State staff will review medical costs which occurred in the twelve (12) months prior to the application in order to determine if it is cost effective to pay the premiums.

3. County Welfare Department (CWD) Responsibilities

The counties' responsibilities are to:

- a. Issue a Health Insurance Questionnaire form (DHS 6155) to the beneficiary to complete during the application and redetermination process, when the beneficiary indicates:
 - 1) that group or employer related health insurance is available, but has not been applied for, or
 - 2) that he/she is about to terminate health insurance coverage or
 - 3) that his/her health insurance coverage has lapsed.
- b. Assure that the sections for beneficiary name, Medi-Cal identification number and beneficiary telephone numbers are complete, accurate and readable.

Special Note: If the beneficiary cannot be given the form in person and the beneficiary notifies the CWD that his/her health insurance has or is about to terminate, or the beneficiary has not applied for health insurance, the Eligibility Worker (EW) must send the Health Insurance Questionnaire (DHS 6155) form to the beneficiary to complete, sign and date. Instructions must be given to the beneficiary to mail the form to the Department of Health Services at the address listed at the bottom of the Health Insurance Questionnaire form (DHS 6155).

- c. Retain a copy of the Health Insurance Questionnaire (DHS 6155) in the case folder.
- d. Advise the beneficiary that providing this information will not interfere with eligibility or use of Medi-Cal benefits. However, explain to the beneficiary that private health insurance must be used prior to using Medi-Cal. Information

will be used solely to determine if the Department will pay the health insurance premiums for the beneficiary.

- e. Tell the beneficiary that DHS may require that Medi-Cal eligibles with existing third party coverage participate in HIPP if it is cost effective for the Department.
- f. Mail, or instruct the beneficiary to mail, the Health Insurance Questionnaire (DHS 6155) within five (5) days following receipt of the information to:

Department of Health Services
Recovery Branch
Health Insurance Unit (HIPP)
P. O. Box 1287
Sacramento, CA 95812-1287

- g. After the county receives a confirmation notice from the Department that the beneficiary has been accepted to the HIPP program, review and recompute the beneficiary's share of cost as necessary in accordance with articles 12A & 12B (Share of Cost) of the procedures portion of the Medi-Cal Eligibility Manual.

4. Department of Health Services' Responsibilities

- a. DHS will review and process the Health Insurance Questionnaire (DHS 6155).
- b. DHS will establish a beneficiary case and a tickler file for annual re-evaluation.
- c. DHS will initiate premium payments to the insurance carrier, employer or beneficiary as appropriate.
- d. DHS will update MEDS with the appropriate OHC indicator.
- e. DHS will notify the CWD and beneficiary of the State's intent to approve or deny HIPP participation.
- f. DHS will re-evaluate premium payment cases annually. In the event health insurance coverage is discontinued, DHS will 1) change the OHC indicator on MEDS to an "N" and notify the county using the DHS 6036 form to update the case file and, 2) notify the beneficiary of the decision to discontinue him/her from HIPP.

5. Notification of HIPP Approval

DHS will notify the CWD, using the HIPP Indicator letter, DHS 6036A, that the Department has approved payment for a beneficiary's health insurance premium. The notice will provide private health insurance

information specific to the Medi-Cal beneficiary. In addition, the letter will indicate the OHC code that the Department will input into the Medi-Cal Eligibility Data System (MEDS).

6. Definition of Health Insurance Coverage

For purposes of the HIPPP program, the five types of health insurance coverage that will be considered for premium payment are: 1) specific illness plans, 2) indemnity plans, 3) basic coverage, 4) basic/major medical coverage, and 5) Medicare supplemental plans. In order to determine a beneficiary's coverage type, eight questions have been developed and printed on the Health Insurance Questionnaire (DHS 6155) (Item No. 10) which should assist the beneficiary to identify his/her type of health insurance coverage. The definitions of these types of health insurance coverage are as follows:

- a. Specific Illness Plan -- Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of a specified illness, such as cancer, poliomyelitis, encephalitis and spinal meningitis.
- b. Hospital Indemnity Plan -- Insurance which provides a stipulated daily, weekly or monthly cash payment during hospital confinement.
- c. Basic Coverage -- Insurance which generally provides reimbursement for the major expenses associated with any illness, particularly those arising from hospital stays, physician visits, surgery, and diagnostic tests both in and out of the hospital. Basic plans typically limit coverage in terms of the maximum expense or frequency of utilization of each service that is covered, although benefits for 120 to 365 days of hospital care, for instance, are not uncommon.
- d. Basic/Major Medical Coverage (also known as Comprehensive Major Medical Coverage) -- Insurance designed to give the protection offered by basic coverage and, in addition, provide health insurance to finance the expense of major illness and injury. Basic/major medical coverage is characterized by large benefit maximums ranging up to \$250,000 or having no limit. The insurance, beyond an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, and drugs. The insured person as co-insurer pays the remainder. A common basic/major medical coverage type is an 80/20 plan whereby the insurance covers 80 percent of the charge and the insured pays the remaining 20 percent.
- e. Medicare Supplemental Plan -- Insurance coverage for persons who are Medicare eligible. These policies supplement the coverage afforded by the federal government under the Medicare

program. Medicare supplemental coverage generally provides the 20 percent co-insurance for Medicare covered outpatient expenses as well as all deductibles.

7. High Cost Medical Conditions

The following is a nonexclusive list of medical conditions related to high cost medical procedures which will be considered for premium payment. If a beneficiary is identified with an AIDS diagnosis, that case will be automatically accepted for HIPPP. Other conditions may be considered on a case by case basis:

<u>MEDICAL CONDITION</u>	<u>TREATMENT</u>
1. Breast cancer.....	Mammoplasty
2. Spinal (vertebral arthritides (severe)).....	Osteotomy and fusions
3. Herniated discs.....	Osteotomy and fusions
4. Scoliosis.....	" " "
5. Upper arm and shoulder cancer.....	Tumor excision
6. Shoulder joint dysfunction.....	Arthrectomy with prosthesis
7. Hip joint dysfunction.....	" " "
8. Knee joint dysfunction.....	" " "
9. Lower leg deformities.....	Femoral lengthening
10. Lower leg cancer.....	Tumor excision
11. Ear, nose, throat cancer.....	Radical neck dissection
12. Lung cancer.....	Pneumonectomy and lobectomy
13. Heart diseases of valves.....	Valvectomy and prosthesis
14. Heart attack.....	Myocardial resection
15. Angina pectoris (heart attack).....	By-pass graft
16. Congenital heart defects (severe).....	Heart transplant & other procedures
17. Aneurysms, blood vessels.....	Aneurysm surgery
18. Stroke and other ischemic conditions.....	Endarterectomies
19. Cirrhosis.....	Portal caval shunts

20. Tongue, jaw, mouth cancer.....Commando procedures
21. Esophageal cancer.....Esophageal resections
22. Stomach cancer.....Gastrectomy
23. Small bowel diseases.....Small bowel resections
24. Large bowel cancer.....Colectomies
25. Liver cancer & congenital defects.....Liver transplant
26. Pancreatic cancer.....Pancretic resection
27. Kidney diseases.....Kidney transplant
28. Urinary bladder cancer.....Resection & reconstruction
29. Prostate cancer.....Resection & radiation
30. Urethral diseases.....Reconstruction
31. Uterine & cervical cancer.....Resection
32. Vaginal diseases.....Resection & reconstruction
33. Abnormal pregnancy & delivery.....C-section
34. Brain tumors.....Craniotomy
35. Brain hemorrhage & aneurysms.....Craniotomy
36. Seizure disorder, pain (Severe).....Stereotactic procedures
37. Spinal cord tumors & defects.....Laminectomy
38. Nerve defects post trauma.....Nerve grafts
39. Corneal defects.....Keratoplasty
40. Cataracts.....Lens replacement
41. Retinal diseases.....Retinal reattachment
42. Strabismus.....Strabismus surgery
43. Acquired Immune Deficiency Syndrome (AIDS).....Various

Special Note: Cases which do not pertain to the above medical conditions but involve high dollar medical expense will be evaluated on an individual basis.

DEPARTMENT OF HEALTH SERVICES

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SACRAMENTO, CA 95814.

HIPP



MEDI-CAL HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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 - a. If coverage is under COBRA Continuation and application is made within 30 days of the insurance termination date.
 - b. If coverage is under a conversion policy and application is made within 20 days.
6. The policy does not exclude the high cost illness.

HIPP will review medical costs which occurred in the twelve (12) months prior to the application in order to determine if it is cost effective to pay the premiums.

The applicant must complete a Health Insurance Questionnaire (DHS 6155). The referral form should be sent with a copy of the policy to:

Department of Health Services
HIPP Coordinator
Health Insurance Unit
P. O. Box 1287
Sacramento, CA 95812-1287

The Department's HIPP unit should notify applicants within 15 working days if they qualify and have been accepted. For further information, contact your County Medi-Cal eligibility worker or call: 1-800-952-5294 between 7:30 a.m. and 4:30 p.m. SPANISH TRANSLATION IS AVAILABLE.